

Michigan Department of Community Health

Board of Dentistry

P.O. Box 30670

Lansing, Michigan 48909

(517) 335-0918

DENTAL SPECIALTY RECERTIFICATION INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Dentistry. Questions regarding your application can be directed to the Michigan Board of Dentistry at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. Applications submitted without the required licensing fee, the applicant's signature and date will be returned.

GENERAL INSTRUCTIONS FOR RELICENSURE:

1. Type or print legibly on all forms and send original application, with the proper fee, to the Board of Dentistry. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application and fee are no longer valid.
2. Complete the relicensure application and return it with the appropriate fee.
3. Verification of specialty license must be sent directly to this office from each state you hold or have ever held a specialty license in.

ORIGINAL LICENSES ARE VALID FOR ONE YEAR OR LESS; SUBSEQUENT RENEWALS ARE GOOD FOR A THREE-YEAR PERIOD.

APPLICATION FOR DENTAL SPECIALTY RE-CERTIFICATION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

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Board Use Only
Specialty License Number
CS License Number
Date of Licensure

I AM APPLYING FOR RE-CERTIFICATION IN THE FOLLOWING:

- ☐ Endodontics ☐ Periodontics ☐ Prosthodontics
☐ Orthodontics ☐ Pediatric Dentistry ☐ Oral Maxillofacial Surgery
☐ Oral Pathology

Fee: \$65.00 71-2911-53 (for each specialty certificate)

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Michigan DDS License Number and Expiration Date
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	
Has your Michigan dental specialty certification been lapsed more than three years? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you been treated for substance abuse in the past 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name

7. Have you ever had a federal or state health professional license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you? ☐ Yes ☐ No

8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? ☐ Yes ☐ No

List each state(s) in which you hold or have ever held a permanent dental specialty license, the license or registration number, the date issued, and how the license was obtained (either endorsement or examination). DO NOT LIST TEMPORARY LICENSES. **You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.)**

State	License Number	Date of Issue	How obtained (Endorsement or examination)

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant

Date

Michigan Department of Community Health

Bureau of Health Professions

P.O. Box 30670

Lansing, MI 48909

VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.		
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Nursing	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> Counseling	<input type="checkbox"/> Nursing Home Adm.	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Dentistry	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Physician's Assistants
<input type="checkbox"/> Marriage & Family Therapy	<input type="checkbox"/> Optometry	<input type="checkbox"/> Podiatry
<input type="checkbox"/> Medicine	<input type="checkbox"/> Osteopathy	<input type="checkbox"/> Psychology
<input type="checkbox"/> Sanitarians	<input type="checkbox"/> Social Work	<input type="checkbox"/> Veterinary
First Name	Middle Name	Last Name
Previous Names Used	Date of Birth	U. S. Social Security Number
State Board	License Number	Date of Issue

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State. Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Basis for Issuance of License:		Type of License:
<input type="checkbox"/> Examination - Please indicate type of exam (National, Regional, State, etc.)	<input type="checkbox"/> Endorsement - Please indicate name of state	
License Status	Original Issue Date	Expiration Date
<input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive		
Has the applicant incurred any formal or informal actions in your State?		
<input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, Please attach certified copies of any actions.		
Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

Signature

Date

Type or Print Name

(S E A L)

Title

Full Name of Licensing Board